NEW FAMILY REGISTRATION

Welcome to our office!

HOW DID YOU HEAR ABOUT US? (please circle one)

Relative or Friend	Saw Our Location	Postcard in Mail	Google	YP.com	Other

Name of referring relative, friend, website, or other source:

PARENT / RESPONSIBLE PARTY (person filling out this form)

First Name	**Last Name**	**Cell Phone**
Employer		**Work Phone**
Email Address		

HOUSEHOLD INFORMATION

Address		
City	**ZIP**	**Home Phone**

ADULTS AUTHORIZED FOR MEDICAL CARE DECISIONS

OPTIONAL: As the responsible party for the patients registered in this account, I authorize the following adults to make decisions regarding their dental treatment. (Examples: spouse, patients' grandparents, etc.)

1	**First Name**	**Last Name**	**Phone**
	Relation to Patients		
2	**First Name**	**Last Name**	**Phone**
	Relation to Patients		
3	**First Name**	**Last Name**	**Phone**
	Relation to Patients		

ACKNOWLEDGMENT OF RESPONSIBLE PARTY

As the responsible party for the patients registered in this account, I understand that the eligibility information that my insurance company provides is not always up to date or correct. Although Kid Focus Dentistry will make reasonable efforts to determine insurance benefits prior to treatment, I understand that I will be financially responsible for any amount that insurance does not pay.

I hereby give my consent for Kid Focus Dentistry to use and disclose my Protected Health Information to carry out treatment, payment, and health care operations. The Notice of Privacy Practices made available by Kid Focus Dentistry describes such uses and disclosures more completely.

Signature of Responsible Party	**Date**

Kid Focus DENTISTRY

PATIENT HEALTH HISTORY

PATIENT INFORMATION

First Name	Last Name	Nickname
Date of Birth	Month Day	Year
Name of School or Daycare		**City**

DENTAL HISTORY

What is the chief complaint?

Last dental exam Month Day Year ☐ This is child's first visit to a dentist

Does the patient have any of the following conditions?

☐ Toothache	☐ Pain around ears	☐ Swelling or lumps in mouth
☐ Traumatic injury to mouth/teeth	☐ Bad breath	☐ Complications from extractions
☐ Grinding teeth or clenching jaws	☐ Mouth breathing	☐ Bleeding gums
☐ Teeth sensitive to cold, heat, sweets, or pressure	☐ Oral habits: thumb sucking, fingernail biting, cheek biting	☐ Problems with prior dental visits

MEDICAL HISTORY

Physician's/pediatrician's office	Date of last exam

Have there been any changes in the patient's overall health in the last year? ☐ Yes ☐ No
Explain:

Has the patient been hospitalized due to illness in the last three years? ☐ Yes ☐ No
Explain:

Does the patient have any of the following conditions?

☐ Allergy to penicillin	☐ Kidney problems	☐ Liver problems or hepatitis
☐ Allergy to latex	☐ Diabetes	☐ Malignancies or leukemia
☐ Allergy to anesthetics	☐ Eye disorders	☐ Thyroid disorders
☐ Hay fever or seasonal allergies	☐ Radiation treatments	☐ Ulcer or colitis
☐ Asthma	☐ Sinus problems	☐ Physical or mental handicap
☐ Heart ailments	☐ Tonsillitis	☐ Psychiatric care
☐ Excessive bleeding	☐ Rheumatic fever	☐ Nervousness
☐ Anemia or blood problems	☐ Immune system disorders	

Any other medical conditions, allergies to drugs, and all medications patient is taking:

Female patients: Are you or could you be pregnant? Are you nursing? ☐ Yes ☐ No

ACKNOWLEDGMENT OF PARENT / RESPONSIBLE PARTY

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in the patient's health or medications taken.

Signature	Date
Print Name of Responsible Party	

Revised 3/20/2013